

MONDAY JANUARY 24th 2005

VERDICT IN SARAH CAMPBELL INQUEST – 18-YEAR-OLD WOMAN WHO DIED IN HMP STYAL

The jury in the inquest of 18-year-old Sarah Campbell has returned a particularly damning narrative verdict. Sarah was the youngest of six women to die in a 12 month period (August 2002 – August 2003) at HMP Styal. Sarah died on 18 January 2003 after swallowing a large amount of prescription tablets.

Today's verdict drew particular attention to the shocking practice at the prison of putting vulnerable prisoners in the segregation unit when they were at risk of self-harm or suicide. At the time of Sarah's death the jury heard that there were three women at risk of self-harm in the segregation unit. In his evidence, the Prison Ombudsman, Stephen Shaw, said that he was shocked because it was potentially unsafe.

Summary of the verdict:

The jury highlighted the following contributing factors:

- In particular the lack of urgency in formulating care plans with regards to location in segregation units.
- A lack of reference to the open F2052SH at reception and through to the segregation unit.
- Lack of communication between healthcare professionals and disciplinary staff.

Other areas of concern include:

- A failure to allocate a safe cell.
- Inadequate staffing levels.
- The failure to follow F2052SH procedures.
- Lack of suitable accommodation for vulnerable prisoners.
- Lack of attention to vital medical information and assessment from outside agencies.
- Lack of structured training.
- Emphasis is placed on auditing rather than prisoner welfare.
- Avoidable delays from the detection of the overdose to arrival at hospital.

The coroner as part of his duty to prevent similar fatalities under rule 43 of the Coroners Rules is going to report to the authorities action he wants taken to prevent similar fatalities.

1. Investigation reports into deaths should be given to staff.
2. The prison should publish its response and any action plan.
3. There should be regular mandatory training in suicide and self-harm supplied to all prison staff and proper staff training records kept.
4. A thematic review of the use of segregation in women's prisons.

5. An immediate review of all staff training within Styal.

Deborah Coles co-director of INQUEST said:

“This verdict is a damning indictment of Styal prison’s failure to protect the life of a vulnerable women at risk of suicide and self-harm. Sarah’s death was a tragedy waiting to happen. The Home Office Minister and prison service management need to explain to the families of the six women who died between August 2002 and August 2003 why they failed to take urgent action to address the systemic failings identified in the previous Inspectorate report of 2002. The prison service are culpable in failing to act on serious deficiencies in the treatment and care of vulnerable women. This inquest has heard shocking evidence that HMP Styal utterly failed in their duty to protect the life of Sarah, a woman who had been clearly identified by several sources as being at risk of suicide and self-harm. This case is a tragic reminder of the need for a fundamental re-think of the way in which women are dealt with by the criminal justice system. INQUEST welcomes the significant recommendations made by the coroner and awaits the necessary response from the prison service.”

Pauline Campbell, Sarah’s mother who has been campaigning on deaths of women in prison since her daughter died said: “As Sarah’s mother I repeatedly warned the prison about her extreme vulnerability and I have been deeply shocked to learn that Sarah was placed on the segregation block where she was effectively isolated and basic procedures were not followed. Callous disregard was shown towards my daughter’s needs and her death should be on the conscience of Her Majesties prison service.”

Note to Editors

A press conference was held at the conclusion of the inquest with Pauline Campbell, Sarah’s mother and Deborah Coles co-director of INQUEST.

Sarah Campbell had a long history of mental health problems which were well known to HMP Styal and at the time of her death she was on suicide watch. Sarah had also been a drug user since the age of 16, though she had been drug-free for eight months at the time of her death. She had been on remand in Styal for six months and then spent two months on bail living with her mother. On 17 January 2003 she was sentenced and returned to Styal. The following day she is believed to have swallowed a large amount of prescription tablets and was taken unconscious to hospital where she died later that evening.

Sarah was one of six women in HMP Styal to die in a twelve-month period between August 2002 and August 2003. Prison Inspectorate reports on Styal prison have identified systemic failings in the treatment and care of women withdrawing from drugs and this inquest will again raise concerns about the treatment and care of women with drug and mental health problems.

Pauline Campbell was represented by INQUEST Lawyers Group members Richard Hermer, Doughty Street Chambers instructed by Mark Scott, Bhatt Murphy, Solicitors.

INQUEST is working with a number of families of the women who died at HMP Styal and continues to be shocked by the rising death toll of women in prison. Last year there were 13 self-inflicted deaths of women in prison. In 2003 there were 14 self-inflicted deaths of women in prison.

INQUEST is the only non-governmental organisation in England and Wales that works directly with the families of those who die in custody. It provides an independent free legal and advice service to bereaved people on inquest procedures and their rights in the coroner’s courts.

Deaths of Women in HMP Styal August 2002 - August 2003							
Name	Classification	Establishment	Ethnicity	Age	Status	Cause	Date Of Death
Julie Bernadette Walsh	Self-Inflicted	HMP Styal	UK White	39	Convicted	Overdose	12/08/2003
Hayley Williams	Self-Inflicted	HMP Styal	UK White	41	Convicted	Hanging	04/06/2003
Jolene Willis	Self-Inflicted	HMP Styal	UK White	25	Convicted	Hanging	20/04/2003
Sarah Campbell	Self-Inflicted	HMP Styal	UK White	18	Convicted	Overdose	18/01/2003
Anna Baker	Self-Inflicted	HMP Styal	UK Black	29	Remanded	Hanging	26/11/2002
Nissa Ann Smith	Self-Inflicted	HMP Styal	UK White	20	Remanded	Hanging	10/08/2002

Source: INQUEST Casework and monitoring